Lakeview Cardiology

31571 Canyon Estates Drive, Suite 228
Lake Elsinore, CA 92532-0425

New Patient Registration Form

Please Print

Today's Date

PATIENT INFORMATION

Full Legal Name (First) (Middle) (Last)				Name of Primary Care Physician	
Address	Apt. No.	City	State	Zip	
E-mail	Home Phone	Work Phone	Cell Phone		
Social Security No.	Sex	Marital Status	Date of Birth	Driver's License No.	State Issued
Employer Name	Employer City	Employer State	Name of referring Doctor or Practice?		
List anyone you authorize this office to share your medical information with (name and relationship to you)					
Permitted Contact Method(s) (circle all that apply) home phone cell phone work phone mail e-mail			Ok to leave message on answering machine/voicemail? Yes___ No___		

SPOUSE'S INFORMATION

Full Legal Name (First) (Middle) (Last)		Home Phone
Occupation	Employer name	Work phone	Cell Phone

INSURANCE INFORMATION

Primary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name/Parent's Name D.O.B.	Policy Holder's Social Security No.	
Secondary Insurance Company Name	Group No.	ID/Certificate No.
Policy Holder's Name		

EMERGENCY INFORMATION

Person to Notify in Case of Emergency	Relationship	Home Phone	Cell Phone

INFORMATION FOR THE PATIENT

1. Patients who carry standard health insurance should remember that professional services are rendered and charged to the patient and not to the insurance company. All patients with standard health care insurance are expected to make payment as services are rendered, regardless of pending insurance, litigation, etc.
2. Patients with contract health plans should present their insurance ID card to the receptionist after completing this form. Some contract health plans (HMOs, PPOs, IPAs, etc) require a copayment at the time of service. Most contract health plans require that the claim be submitted by our office.

Patient/ Guarantor Signature: _____ Date: _____

Lakeview Cardiology *(951)471-0200 Fax (951)240-3715*
Shadi A. Qasqas, M.D. *31571 Canyon Estates Dr. # 228 Lake Elsinore, CA 92532*

OFFICE FINANCIAL POLICY

Payment Responsibility- Patient and/or Guarantor assume responsibility for all charges resulting from treatment provided by Shadi A. Qasqas, M.D. and his staff. As a courtesy service for our patients, we will bill most insurance carriers in expectation of prompt payment. However, responsibility for unpaid balances is that of the patient and/or guarantor. Payment for service is due within 30 days of billing, unless financial arrangements are made in advance. We accept cash and credit cards only; we do not accept checks.
It is the responsibility of the patient and/or guarantor to understand the terms and conditions of their insurance plan. Insurance providers do not always cover preventative or well care visits. Contact your carrier's Member Services Department for clarification. When insurance information is unavailable or invalid information is provided at the time of service, the patient and/or guarantor may be held responsible for charges incurred.

Initial Visits- Patient and/or Guarantor are required to pay estimated charges related to their first appointment at time of service. Individuals excluded from this are contracted HMO/PPO enrollees with current eligibility, Medicaid enrollees, and Medicare subscribers.

Appointment Requirements- For each Visit, Patient and/or guarantor are required to bring Photo ID, the patient's current insurance identification card(s), and applicable co-payment. They must also advise the clinic of any change in insurance coverage and communicate change in name, address, telephone numbers, and employer. Missed appointments without a 24-hour prior notification are subject to a $25 fee. This fee is not covered by your insurance and thus will be billed to the patient directly.

Forms- Due to the considerable time involved in the completion of forms, our practice will charge a $15 form fee. This fee will be billed to patient directly and is not covered by your insurance company. Payment is due at time of pick up. Please allow 15 working days to complete all forms.

Medical Records- Request for medical records will require a fee of $15 with a $0.25 per page copied. This fee will be billed to the patient directly and is not covered by your insurance company. Payment is due prior to records being released. Requests will be processed within 10 working days, unless in the event of an emergency, records will be provided as soon as possible. Records will have to be picked up by the patient or authorized party.

Cash Patients- All services are rendered on a cash basis and must be paid in full at the time of service.

HMO/PPO/HAS plans- Co-payment is due at the time of each visit. HMO/PPO enrollees may not receive regularly monthly statements unless there is a balance due. Failure to pay the co-payment at time of visit may result in a billing fee. HAS members may be required to pay a portion at time of service if deductible is unmet.

Employer Sponsored Health Insurance- Shadi A. Qasqas, M.D. will bill most employer sponsored insurance carriers as a courtesy service for our patients. Secondary insurance carriers, when contracted with Shadi A. Qasqas, M.D. may also be billed as a service for our patients when secondary insurance information is presented at the time of service.

Medicare- We must have a copy of your Medicare card and any Secondary insurance you may have. We do not accept assignment of Medicare claims, which means, you will be responsible only for your deductible and 20% of allowed charges. There are certain procedures and supplies which are NON-Covered services for Medicare patients. If you need such services, you will be informed that they are not covered and if you still which to receive such services in this office they will be on a cash basis at the time of service.

Amounts which are over 60 days past due by an insurance company are immediately due from the patient. Amount over 90 days past due are subject to collection procedures, which could include small claims court, or a 1.5% service charge per month on the unpaid balance.

I have read and understand the above.

Patient name (Printed) _____

Patient Signature _____ Date _____

AUTHORIZATION FOR USE AND DISCLOSURE OF MEDICAL INFORMATION

This authorization allows the healthcare provider(s) named below to release confidential medical information and records. Note: Information and records regarding treatment of minors, HIV, psychiatric/mental health conditions, or alcohol/substance abuse have special rules that require specific authorization.

AUTHORIZATION

I hereby authorize: **Shadi A. Qasqas MD Inc. & Affiliated Providers**
Physician/Healthcare Facility

To release information regarding my medical history, illness or injury, consultation, prescriptions, treatment, diagnosis or prognosis, including x-rays, correspondence and/or medical records including those from my other health care providers that the above named health care provider may hold, by means of mail, fax, or other electronic methods.

To: _____
Name

_____
Address

_____ _____ _____
City State Zip Code

The medical information/records will be used for the following purpose: _____

This authorization is:

[ ] Unlimited (all records, excluding Substance Abuse, Mental Health, HIV Diagnosis/Treatment)
[ ] Limited to the following medical information: _____

I also consent to the specific release of the following records:

Drug/Alcohol/Substance Abuse _____(initial)
Psychiatric/Mental Health _____(initial)
Tests for Antibodies to HIV _____(initial)
HIV Diagnosis/Treatment _____(initial)
Genetic Information _____(initial)

DURATION

This authorization shall be effective immediately and remain in effect until _____
Date (MM/DD/YYYY)

RESTRICTIONS

Permissions for further use or disclosure of this medical information is not granted unless another authorization is obtained from me or unless such disclosure is specifically required or permitted by law.

A photocopy of facsimile of this authorization shall be considered as effective and valid as the original.

I have been advised of my right to receive a copy of this authorization.

_____ _____
Signature of patient or legal/personal representative Date

_____ _____
Patient's Name (PRINT) Relationship if other than patient

_____ _____
Patient's Social Security Number Patient's Date of Birth

_____ _____ _____
Witness name Witness signature Date

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ADVANCE HEALTH CARE DIRECTIVE

Dear Patient,

As your specialist, we are obligated to have a current advanced health care directive so that we can incorporate the information into your medical record. You are not required to give us this information, but we are required to ask.
Please complete the form and return it to the receptionist.

Patient Name: _____ **SS#:** _____

Patient Signature: _____ **Date:** _____

- Do you have an advanced health directive? _____Yes _____NO

- Do you have an advanced health directive?
    - Durable Power of Attorney for health care _____
    - California Natural Death Act _____
    - Living Health Will _____
    - Other: _____
- Please bring a copy of your policy _____
- I decline to answer these questions _____

Internal Office use only

Type of health care directive received: Date received:

___Durable Power of Attorney for Health Care _____

___California Natural Death Act _____

___Living Health Care Will _____

Other: _____ _____